Self-help and support groups, run by and for people with HIV and their partners and families, are being set up in many countries. As contributors to this issue of *AIDS Action* explain, these groups help people affected by HIV/AIDS to maintain control over their own lives, by providing practical and emotional support, lobbying for funds and care, and campaigning against discrimination.

‘Disclosure’ or ‘going public’ (when an HIV-positive person makes their status known to others) is an important part of AIDS prevention. Openness about being HIV-positive helps people to accept that AIDS is part of everyone’s lives, whether they are infected or not, or do not know their status. Secrecy hinders prevention efforts, and causes distress for individuals and their families.

Maxwell Mudarikiri, who talks to *AIDS Action* on page 2, describes his own experience: ‘Going public plays a crucial role in the fight against AIDS, as it brings those who don’t know their status closer to the reality of the epidemic. Revealing my status was a way to do something about the discrimination and isolation faced by people with HIV.

‘But coming out as HIV-positive should never be forced. People living with HIV should always be able to choose to maintain their confidentiality, without feeling any pressure to go public.’

**Enormous risk**

So long as there is discrimination, fear and stigma, coming out as HIV-positive – even to family and friends – means taking an enormous risk. This is particularly true if someone is already vulnerable to prejudices held by others (an experience described in the article from Malaysia on page 4).

As reports in this issue reveal, it is also clear that some people with HIV are feeling pressurised to participate in AIDS education and training, without receiving payment. At the same time, they are not involved in making decisions about policy and programme issues.

Support groups have an important role in protecting people from abuse, enabling those who choose to go public to feel confident that their contribution will be valued. Many self-help groups do have very close and beneficial links with other organisations, or are financially supported by them. Forming a support group does not mean working separately from other AIDS organisations, but complementing what they do. Both can benefit within the context of a more equal relationship.

Support and solidarity: celebrating the launch of Positively Living, the first self-help group for people with HIV/AIDS in Malaysia.

**In this issue:**

- Self-help groups set up by and for HIV-positive people
- Check your facts! Questions and answers on HIV/AIDS
- Definitions reviewed: AIDS and symptomatic HIV infection

The international newsletter on AIDS prevention and control: 177,000 copies worldwide in five language editions
**Skilled educators, not ‘teaching-aids’!**

How can self-help groups support people affected by HIV/AIDS? Maxwell Mudarikiri talked to *AIDS Action* about the group he helped to start in Zimbabwe.

*AIDS Action*: What led you to set up the group?

**Maxwell Mudarikiri**: When I was diagnosed as HIV-positive, I really wanted to meet and talk with others in my situation. I needed a support group where people could help each other, without being patronised or treated like victims. People with HIV/AIDS can be responsible for their own welfare and well-being, if the resources for doing this are within their reach.

We set up AAARP (Association for AIDS-Affected Resource People) to help co-ordinate groups in Zimbabwe for people with HIV/AIDS and their relatives and friends. The national AIDS programme has supported us, providing a meeting room and some funds.

**AA**: How do members benefit from the group?

**MM**: Often people just want to talk with others who are HIV-positive. For those who have recently had a positive test result, it can help to meet people who are HIV-positive and healthy. There are so many shared fears about getting ill and dying young, and being stigmatised and rejected.

Most people are worried about financial problems. Some members have been dismissed from their jobs, or have left through fear of colleagues finding out about their status.

Some meetings are only for people who know they are HIV-positive, so they can feel secure that everyone shares their experience. It can be very embarrassing to reveal some things unless you really trust that people will understand. Sometimes you think you are going mad, but at least others who know how it feels won’t think that the virus is making you crazy!

Many of our members are women, and sometimes they meet separately. I feel that women are more accustomed than men to talking about emotional issues. Often they want support in telling their partners, and in encouraging them to come to meetings too.

The association is for both sexes, but sometimes women meet separately.

**AA**: What other practical support does the group offer?

**MM**: Needs vary according to a person’s situation. We try to help each other, by visiting people at home or in hospital, and sometimes through loaning money or taking care of the children. Through the national AIDS programme we receive grants for people to start up small businesses themselves. This helps increase self-esteem, as well as providing self-employment. Examples are catering, making clothes or T-shirt printing.

We also act as a lobbying group. Some AIDS organisations have funds, for example to support a family if the earner has died. We make sure that these are publicised more, and help people with making applications. Similarly, it is easier to get treatment or accommodation from the health and social services with back-up from AAARP. The group increases an individual’s power to get what she or he needs.

**AA**: Why does the association have ‘resource people’ in its name?

**MM**: Increasingly people with HIV are being involved in education and training programmes. However, we have found that individuals are being pressurised to give testimonies, and are rarely paid. Sometimes it feels as if the so-called experts are using people with HIV/AIDS as ‘teaching-aids’. One of our major concerns is to prevent the abuse of people who are HIV-positive or affected by AIDS. Our members are ‘resource people’ – trained educators who are paid for their work. They can choose whether or not they reveal that they are HIV-positive. About three-quarters of our membership now give talks for other organisations, and they feel it is a valuable way of gaining confidence.

We provide training in health education techniques. People also need to know how to deal with prejudiced comments, like: ‘Names of people with the virus should be made public so that others can avoid catching it.’ One answer to that is: ‘Imagine if you had an STD. How would you feel if everyone else knew about it, and avoided you?’

**AA**: How can new members join AAARP?

**MM**: Most AIDS organisations, as well as some doctors, recommend us to their clients who have tested positive. The client is referred to a named group member, who then arranges one or more one-to-one meetings. When the new member feels ready, they come along to a meeting, having met up with their contact first.

**AA**: How do you make sure of confidentiality?

**MM**: There is a lot of trust between members and we have very clear rules about when names can be used. Also, the group is for people affected by AIDS, not necessarily infected by HIV. This means that people cannot assume that every member is HIV-positive. This gives us all some safety.

This interview is published in memory of Tendai, Maxwell’s wife, who did so much to support him in loving and living positively, and who was tragically killed in a car accident in September 1992.
Self-help groups can....

- Provide practical support for individuals and their families, such as:
  - one-to-one counselling and group discussion sessions
  - phoned lines for anonymous counselling
  - home care (for women, for example, who may have no access to other support)
  - fundraising for resources for home care and treatment
  - access to sympathetic lawyers and religious ministers
  - childcare and orphan support
  - income generating schemes
  - hospital and home visits
  - mutual financial help
  - providing information to members about positive living, self-care and preventing HIV.

- Campaign for the rights of people affected by HIV/AIDS by lobbying for:
  - representation on boards of national AIDS programmes or AIDS organisations, for example
  - continued employment (through government and trade union policies, workplace education and legal support)
  - access to financial support, accommodation and health care
  - accurate representation of the issues in the media
  - awareness of the particular issues faced by women and marginalised groups such as sex workers, men who have sex with men and drug users.

- Participate in public AIDS education by:
  - training members in education and counselling skills
  - running workshops for health workers and others
  - linking up with other organisations and institutions, for example, to provide them with speakers and plan joint education programmes.

Problems with an AIDS organisation led to a new local group.

Taking control of my life

I found out that I was HIV-positive in 1991 after the severe illness and death of my husband. Afterwards, I became interested in being trained as a counsellor and educator, so I joined a local AIDS organisation.

However, the workers there had a negative attitude towards people with HIV/AIDS. We felt that they looked down on us, forgetting that the centre would not have existed without HIV-positive people. They were not keeping our status confidential. Our voices were not heard, and we were not involved in planning or decision making.

I also feel that I have been exploited by them. They put pressure on me to go to schools and public places like beer halls and sports clubs. Before this I had never been in a beer hall, but I had to share my testimony with a crowd of drunken people. In return I received nothing and money raised went to the organisation.

There were quite a few of us in this situation, so we decided to form our own support group for self-help. Most of our members are HIV-positive, but there is no pressure on anyone to publicise their status.

Our support group is open to both sexes, but at the moment only women are members, because they are the most interested. We also welcome friends and family members at the meetings.

The death of a partner has meant financial hardship for most of us. Some of us have also lost our jobs (either because we were dismissed, or because of caring for a sick person). We're trying to raise money for sewing machines, and to set up a workshop for our new co-operative.

We are creating a good atmosphere on our own, even though we don't have funding. We listen to each other, and support, counsel and encourage each other to live positively.

Women in the group are feeling more confident and able to come out as HIV-positive to their families and friends.

Name and address supplied.

A forum for women was set up within a mixed group in Kenya.

Women meet with women

Positively Women of TAPWAK (The Association for People With AIDS in Kenya) was started in May 1992. Our culture makes it difficult for men and women to talk about certain subjects together. So we felt that, as women living with HIV/AIDS, we needed a forum to discuss, for example, health problems, and how to increase control over our sexuality. In view of women's disadvantaged status, the group also campaigns for treatment, employment, housing (hotel and hostel accommodation, for example), and education for infected and affected children.

About three quarters of the group are HIV-positive, while the rest are family members and supporters, from the Society of Women and AIDS in Kenya, for example. Together with local NGOs, the Kenya Red Cross, and the national AIDS programme, our group organises workshops to try and increase people's understanding of HIV/AIDS, and to reduce the stigma associated with HIV infection. Through counselling, group discussion sessions, and participating in education and income generating programmes, women are learning to live positively and this has helped some of them go public.

Dorothy O Onyango, Positively Women of TAPWAK (POWOTA), PO Box 30583, Nairobi, Kenya.
Self-help groups

'Ve need to create a voice for HIV-positive people in Malaysia.'

Responding to local needs

Pink Triangle, the only community-based group working with men who have sex with men in Malaysia, took the first steps towards launching a self-help project in August 1992.

The project co-ordinator, Jack Jagjit Singh, who is open about his HIV-positive status, says: 'My experience – being denied treatment because of my homosexuality and given wrong information about how I should take care of myself – has been very frustrating. I wanted to meet up with other people in similar situations. We need to create a voice for people who are positive, and to get a group going.'

The new group has been publicised through Pink Triangle’s public education events, as well as through hospitals and other NGOs. For the first time information is being published specifically by and for people living with HIV/AIDS. Even more importantly, a phoneline has been set up. Now people with HIV can talk anonymously with someone who shares their experience.

Many callers are men who identify as gay (men who have sex with men), who face great prejudice. Not surprisingly, it is very difficult for them to trust anyone else with personal information. Jack comments: 'As yet we have not had a group meeting. Although I meet up regularly with individuals who contact the group, they are not ready to meet each other. But at least they are able to discuss the issues openly with me.'

A safe environment for the group, where the needs of people with HIV/AIDS are understood and respected, is very important. Jack has been invited to join Pink Triangle’s management board to ensure that Positive Living is represented at the policy-making level. And all Pink Triangle volunteers are receiving HIV-awareness training, about the importance of confidentiality, for example.

However, supporting people who are HIV-positive, and fighting for their rights, is new in Malaysia, and Jack is just one person: 'Getting the project going has made me feel strong – strong enough to fight the virus within me. But I do feel the pressure and demands on me growing. I get tired, and need support, especially from Positive Living.'

Pink Triangle is being realistic about what can be achieved in Malaysia. The group must develop in response to people’s needs, and not according to a model imported from outside the country.

Julian Jayaseelan, AIDS Programs Director, Pink Triangle, PO Box 11859, 50760 Kuala Lumpur, Malaysia.

Steps ahead

At an international conference last year, I met HIV-positive women from 27 countries. When I heard that women are setting up support groups, I was encouraged to try to start one in my own country. Women feel freer to express themselves when there are no men present – men tend to dominate meetings. I also feel that women are closer to children, and are more involved in caring for orphans.

I submitted a proposal to the AIDS control programme, who assured me that they would give me funding once I had identified potential members. I began by going round the clinics and hospitals, asking doctors to tell HIV-positive women about the idea. No one would give me any names because I had no identification.

Then I tried talking to religious groups, as I myself am a member of a group. I asked them to introduce me to women (after gaining their permission). But still no one came forward. People here still think AIDS is a dreadful disease, and cannot tell anyone for fear of being rejected or losing friends. Following the programme’s advice, I started a Women and AIDS Action Group, in the hope that out of this would grow a forum for HIV-positive women. But, after some people learnt about my status, they stopped coming to meetings.

Despite all the work I have put into setting up the group, I have still received no financial assistance. But, although I am facing many problems, I am determined to achieve my goal.

Name and address supplied.

Resources and contacts

The International Community of Women Living with HIV/AIDS (ICW) was founded by women from 27 countries at the 1992 international AIDS conference.

Through encouraging information exchange and co-ordinating networking activities, ICW is supporting HIV-positive women in setting up self-help groups, and campaigning against discrimination.

Contact Jo or Kate, ICW, PO Box 2338, London W8 4ZG, UK.

The Global Network of People Living with HIV/AIDS (GNP+) promotes the self-empowerment of people living with HIV/AIDS. Activities include networking, conferences and meetings, information exchange and sponsoring self-help groups by providing technical support. For example, one of GNP’s members helped start a group in Rwanda in 1991, with support from the Norwegian Red Cross. Contact Pascal van den Noort, GNP+, c/o 130 Harley St, London W1N 12AH, UK.

Living with AIDS in the community: a booklet to help people make the best of life was first published in Uganda by the AIDS Control Programme and TASO (The AIDS Support Organisation). Contents include common feelings about a positive test result and information on self-care. Single copies are available free to readers in developing countries from DST/GPA/WHO, CH-1211 Geneva 27, Switzerland. Payment may be due on bulk orders and orders from developed countries.
Check your facts

AIDS Action answers some questions raised by readers about HIV/AIDS.

Q What is HIV?
A The letters ‘HIV’ stand for Human Immunodeficiency Virus. Viruses are the smallest of all disease-causing organisms. HIV only infects human beings, and attacks the body’s immune system. Sometimes HIV is called the AIDS virus, because being infected with HIV can lead to AIDS. But having HIV infection is not the same as having AIDS.

Q How does HIV affect the body?
A The virus destroys a type of white blood cell. These white blood cells have an important role in the immune system which protects the body against illnesses. Soon after being infected, some people may suffer flu-like symptoms for a week or two, but otherwise there are no signs of early HIV infection. Once infected, a person is infected for life and as yet there is no cure, either through traditional or modern medicine. A person infected with HIV (or who has AIDS) can pass on the virus to someone else.

The virus may remain inactive for many years, and this is why people who have HIV often stay healthy, and look the same as people who do not have the virus. If the virus becomes more active, it can damage the immune system considerably and the body becomes less able to resist illnesses.

Q What is AIDS?
A AIDS stands for Acquired Immune Deficiency Syndrome. Getting (acquiring) HIV infection leads to a weakened (deficient) immune system. This makes a person with HIV vulnerable to a group of symptoms (syndrome) and illnesses that a person without the virus would be unlikely to be affected by (opportunitic infections). It is the development of these illnesses that leads to a diagnosis of AIDS. They can develop from within a few months to over ten years after initial HIV infection. The time taken depends on the infected person’s state of health and other factors, like access to treatment.

Q What is the HIV test?
A The HIV test detects whether someone’s blood has developed antibodies to HIV. Although the test does not detect the virus itself, having antibodies to HIV means that the person is HIV-infected (antibody positive, seropositive or HIV-positive).

If there are no antibodies, the person is antibody negative (seronegative or HIV-negative). However, the test result can be negative if the person has been infected only recently, because it can take up to six months from the time of infection for antibodies to develop. This is called the ‘window period’.

Q How do you get infected with HIV?
A HIV is found in an infected person’s body fluids, mainly in blood (including menstrual blood), semen and vaginal secretions. The virus is not that easy to catch. For HIV to be transmitted, it must pass from someone’s infected blood, semen or vaginal secretions directly into another person’s bloodstream or body tissues, often through the mucous membranes lining the inside of the vagina, penis or rectum. The virus cannot pass through unbroken skin.

The virus has also been found in breastmilk. There is a risk of transmission from an infected mother to her baby, during pregnancy or delivery, or through breastfeeding. This could apply to about a third of all babies born to mothers who have been infected with the virus, although as yet it is not possible to measure the level of risk in each individual case or to say exactly when or how the virus is passed on.

Very small amounts of the virus have been found in saliva, tears, vomit, faeces and urine, but there is no evidence that these fluids transmit infection. HIV has not been found in, and is not transmitted by, sweat.

Q What is high risk behaviour?
A High risk behaviour means activities that increase the risk of infection for you or someone else. It is not always possible to know who has HIV and who does not, including yourself (unless of course you know that you and/or your sexual partner is HIV-positive). The following activities are therefore always very risky to other people and yourself:

- Having penetrative vaginal or anal sex (where the penis enters the vagina or anus), without using a condom. This is called unprotected sexual intercourse. The more partners you have unprotected sex with, the higher the risk of infection. Women and men can infect each other through unprotected vaginal or anal sex. The risk of transmission from a man to a woman is higher than from a woman to a man. Men can infect each other through unprotected anal sex.

- Using unsterilised needles and syringes, or cutting instruments, on yourself or someone else, that have been used and therefore are likely to be contaminated by another person’s blood.

- Receiving an infected blood transfusion.

Q How is the virus not transmitted?
A The virus can survive only in the body fluids inside a living human body. Once blood and other body fluids are outside the body, HIV survives for only a few hours. Also, HIV cannot pass through unbroken skin.

HIV is not transmitted by mosquitoes or other blood-sucking insects. This is because most insects inject saliva, not blood, when they bite a human. The parasite which causes malaria enters the bloodstream in mosquito saliva. Hepatitis B, which is much more infectious than HIV, is not spread by insects either.

Please write to AIDS Action with any other questions.
Diagnosing symptomatic HIV infection and AIDS in adults

In 1982, the Centers for Disease Control in the USA listed conditions and infections then associated with the serious immune deficiency caused by HIV infection, and defined them as the Acquired Immune Deficiency Syndrome or 'AIDS'. This case definition was designed primarily for epidemiologic surveillance, and now includes over 20 conditions.

The US definition has been used as a model in many other countries. However, it requires diagnostic and laboratory technologies (including HIV testing facilities), which are not always available in developing countries. In 1985 the World Health Organization published the Bangui definition, which uses clinical criteria alone. Many developing countries have adapted this definition, because illnesses associated with immune deficiency may vary according to the disease-causing organisms in different regions.

Defining AIDS: pros and cons

The clinical definition is relatively specific (if used correctly), meaning that the vast majority of people diagnosed as having AIDS will have been correctly assessed. However, studies show that the definition is relatively insensitive, meaning that only half the patients who have severe illness related to HIV infection are included. This is because not all HIV-related opportunistic diseases are in the AIDS definition.

Tuberculosis is widely recognised as the commonest opportunistic disease associated with HIV in Africa. But because TB causes wasting, cough and fever in most patients, the AIDS clinical case definition cannot reliably distinguish between HIV-positive and HIV-negative TB patients.

The clinical case definition was developed to enable reporting of the number of people with AIDS for the purposes of public health surveillance, rather than for patient care. It does not include everyone with symptomatic HIV infection, but only people with severe HIV disease.

However, for the purposes of individual case management, it is useful to be able to diagnose whether illnesses may be related to HIV infection (symptomatic HIV infection) because:

- clinical manifestations can be a reliable indicator of underlying HIV infection;
- over-use of HIV testing is avoided; testing is used to confirm suspected HIV infection, rather than as a diagnostic tool in the first instance;
- a patient with suspected HIV infection can be counselled about having an HIV test, the implications for them and their sexual partners, self-care and nutrition;
- many HIV-related illnesses can be treated, improving the patient's quality of life;
- certain drugs (such as thiacetazone) cause severe side effects in people with HIV infection, and should not be prescribed for them.

AIDS clinical definition

The presence of generalised Kaposi sarcoma or cryptococcal meningitis is sufficient for the diagnosis of AIDS.

AIDS is also diagnosed if at least two major signs and one minor sign are present, in the absence of known causes of immunosuppression such as malnutrition.

Major signs
- fever for more than one month
- weight loss more than 10 per cent of body weight
- diarrhoea for more than one month

Minor signs
- cough for more than one month
- generalised pruritic dermatitis
- recurrent herpes zoster or shingles
- oropharyngeal candidiasis or thrush
- chronic or aggressive ulcerative herpetic simplex
- persistent generalised lymphadenopathy

Diagnosis for care

In view of these issues, the World Health Organization has developed criteria for diagnosing symptomatic HIV infection, as an aid to individual case management. The criteria are not intended to replace the case definitions developed for epidemiological purposes. In some countries, including Malawi, Zambia, Thailand and the English-speaking Caribbean, they are being adapted for national use.

The new criteria also have their advantages and disadvantages. Although more exact than the AIDS case definition, the criteria require more invasive diagnostic tests and are more complicated for health workers to use.

Symptomatic HIV infection can be recognised clinically without testing for HIV antibodies. However, confidential HIV testing can be used to confirm a clinical diagnosis, provided that the patient's consent is obtained, with pre- and post-test counselling.

The diagnosis of symptomatic HIV infection is when a person has HIV infection, and is healthy, although there may be signs of persistent generalised lymphadenopathy.

Symptomatic HIV infection or HIV disease is when a person has HIV infection, together with illnesses related to underlying immune deficiency. These illnesses may be mild, moderate or severe, depending on the degree to which a person's immune system is damaged by the virus. If severe, these illnesses may be within AIDS or ARC (AIDS-related complex) definitions. However, severe HIV disease also includes life-threatening illnesses not included in the definitions. It is now recognised that the course of symptomatic HIV infection is characterised by episodes of illness, followed by recovery and periods of health.
A person has symptomatic HIV infection if there are:

**One or more cardinal findings;**

**Two or more characteristic findings;**

**One characteristic finding and two or more associated findings;**

**Three or more associated findings, together with any risk factors** (found by taking the case history);

**Two associated findings, with a positive HIV test result.**

### Cardinal findings

- Kaposi sarcoma (lesions in the mouth, or generalised or rapidly progressive)
- Oesophageal candidiasis
- Cytomegalovirus retinitis
- Pneumocystis carinii pneumonia
- Toxoplasma encephalitis

### Characteristic findings (if no other obvious cause of immunosuppression such as malnutrition is present)

- Oral thrush (in a patient not taking antibiotics)
- Hairy leukoplakia
- Cryptococcal meningitis
- Miliary, extrapulmonary or non-cavity pulmonary tuberculosis (disease in lymph nodes, lung or heart walls, or in lungs, often without cavities showing on X-ray)
- Herpes zoster or shingles (present or past, particularly if the patient is not elderly)
- Severe prurigo
- Kaposi sarcoma (other than type described as cardinal finding)
- High-grade B-cell extranodal lymphoma (tumour of the lymph cells frequently located in the gut or central nervous system)

### Associated findings (if no other obvious cause of immunosuppression is present)

- Recent and/or unexplained weight loss of more than 10 per cent of the body weight
- Fever (continuous or intermittent) for more than one month
- Diarrhoea (continuous or intermittent) for more than one month
- Ulcers (genital or around the anus) for more than one month
- Cough for more than one month
- Neurological complaints or findings, including seizures; peripheral neuropathy (degeneration of the nervous system); dementia; progressively worsening headache
- Generalised lymphadenopathy
- Drug reactions (previously not seen) e.g. to thiacetazone
- Severe or recurrent skin infections

### Possible risk factors for HIV infection

- Present or past high risk behaviour:
  - Unprotected penetrative anal or vaginal sex with several sex partners
  - Drug injecting with shared syringes and needles
  - Sex partners with known AIDS or HIV infection
  - Sex partner of someone with a known risk factor
- Recent history of an STD, particularly genital ulcer disease
- History of unscreened blood or other transfusion after 1975, or from an area with high prevalence of HIV infection, even if screened
- History of scarification, tattooing, ear piercing or circumcision using non-sterile instruments

### HIV infection in women

HIV-related conditions specific to women have not yet been fully researched. Apart from invasive cervical cancer (added to the US definition in 1992), none of the following conditions are included in the definitions, but studies indicate that they can be associated with HIV infection.

**Amenorrhoea** (absence of menstruation) may indicate HIV infection in women of reproductive age, although it has many other causes. It can occur at any stage of infection, including before other signs or symptoms are present, and also when a woman has advanced HIV illness.

**Recurrent or persistent vaginal candidiasis** (yeast infection or thrush) often precedes oral thrush as one of the earliest signs of HIV infection. However, vaginal thrush is a common infection, and can also be a complication of treatment with antibiotics. Symptoms can include a thick, odourless white or yellow vaginal discharge; genital inflammation; and raised white and grey patches on the vaginal skin.

**Severe pelvic infections with abscess formation** (severe pelvic inflammatory disease) may be caused by underlying HIV infection, but are also found in women who are not HIV-infected. Symptoms include abdominal and lower back pain, which often gets worse before and during menstruation.

Continued on next page...
Cervical cancer may be more common among women with HIV infection. Cancer of the cervix (the head and neck of the uterus, situated at the top end of the vagina) can include neoplasia (superficial cancer on the cervix surface); and invasive or deeply embedded cancer. Cervical dysplasia (abnormal cell development) is more common in women with HIV infection, but may be caused by a viral infection rather than being an early sign of cervical cancer.

Sources: Dr H Friesen, Rubaga Hospital, PO Box 14130, Kampala, Uganda, and Drs E Ekpini, T Sibailly and K De Cock, Projet Retro-Cl, BP 1712, Abidjan 01, Côte d’Ivoire and GPA/WHO.

Glossary

Persistent generalised lymphadenopathy. Lymph nodes are larger than one centimetre in diameter, in two or more sites other than the groin area for a period of at least three months.

Kaposi sarcoma. A tumour featuring reddish brown or purplish plaques or nodules on the skin and mucous membranes. Endemic in Africa prior to HIV, it used to affect mainly older men. With HIV infection it affects a wider age range and both sexes, and is characterised by lesions in the mouth or gut; or lesions are generalised (in two or more places) or rapidly progressive or invasive.

Oropharyngeal candidiasis. Caused by a common yeast fungus, oral thrush presents with soreness and redness, with white plaques on the tongue, and in the mouth and throat; and sometimes a white fibrous layer covering the tonsils and back of the mouth. Infection of the oesophagus presents with pain behind the breastbone.

References and resources

1. Guidelines for the clinical management of HIV infection in adults. Single copies are available free from DST/GPA, WHO, CH-1211 Geneva 27, Switzerland to health workers in developing countries.

Women and HIV/AIDS: an international resource book, edited by Marge Berer with Sunanda Ray, provides a comprehensive and practical overview of how women’s health, sexual relationships and lives are affected by the virus. The book includes examples of leaflets and posters; descriptions of education and care programmes; and an international resource list of organisations and materials.

Readers in developing countries can order the book at a reduced price from AHRTAG. The book is commercially available to other readers and the book trade at £14.99 per copy. Contact Sales Dept, Pandora Press, HarperCollins UK, 77-85 Fulham Palace Rd, London W6, UK.

Herpes zoster or shingles. Viral inflammation of the central nervous system, presenting with localised pain and burning sensations, followed by vesicle eruption (skin blistering) and ulceration.

Severe prurigo or pruritic dermatitis. Chronic skin inflammation in the form of a very itchy rash of small flat spots developing into blisters.

Severe or recurrent skin infections include warts; dermatophytosis or ringworm; and folliculitis (inflammation of hair follicles).